United Nations A/HRC/29/33/Add.1

General Assembly

Distr.: General
1 May 2015

Original: English

Human Rights Council
Twenty-ninth session
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras

Addendum

Visit to Malaysia (19 November–2 December 2014)*

Summary

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health visited Malaysia from 19 November to 2 December 2015. During the visit, the Special Rapporteur considered, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health. In particular, he assessed issues related to: the health-care system and financing, and the right to health of particular groups, such as women and girls; indigenous communities; migrants, refugees and asylum seekers; lesbian, gay, bisexual and transgender (LGBT) persons; persons living with HIV/AIDS; children; and persons with psychosocial and developmental disabilities.

In the present report, the Special Rapporteur commends Malaysia for its commitment to realizing the right to health, in particular for advances made in reducing poverty, increasing spending on health, and improving basic health-related indicators. For Malaysia to fully realize the right to health, however, the Special Rapporteur encourages the Government to address a number of serious challenges that are mostly connected to a selective approach to human rights and the prevalence of discrimination against groups in vulnerable situations. With a view to facilitating that endeavour, the Special Rapporteur makes a number of recommendations in the report.

* The summary of the present report is being issued in all official languages. The report itself, contained in the annex to the summary, is being issued in the language of submission only.

GE.15-08706 (E)

1508706

Please recycle

Annex

[English only]

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Malaysia (19 November–2 December 2014)

Contents

		Paragraphs	*Page*
I.	Introduction	1–4	3
II.	Right to health	5–16	3
	A. Background	5–11	3
	B. International and national legal framework	12–16	4
III.	Health system and financing	17–24	5
IV.	Groups in vulnerable situations	25–107	7
	A. The right to health of women and girls	26–45	7
	B. Indigenous communities	46–54	10
	C. Migrants, refugees and asylum seekers	55–82	12
	D. Lesbian, gay, bisexual and transgender persons	83–90	16
	E. Persons living with HIV/AIDS and drug users	91–98	17
	F. Children and the right to health	99–104	18
	G. Persons with developmental and psychosocial disabilities	105–107	19
V.	Conclusion and recommendations	108–111	20

I. Introduction

1. In the present report, the Special Rapporteur gives details of his visit to Malaysia at the invitation of the Government from 19 November to 2 December 2014. The purpose of the visit was to ascertain, in a spirit of dialogue and cooperation, how the country has endeavoured to implement the right to health.

2. During his visit, the Special Rapporteur held meetings with government officials from the Economic Planning Unit of the Prime Minister's Department and the Ministries of Foreign Affairs; Health; Home Affairs; Education; Women, Family and Community Development; Rural and Regional Development, including the Department of Orang Asli Development; Urban Wellbeing, Housing and Local Government; and Human Resources. He also held meetings with representatives of the National Human Rights Commission (Suhakam), civil society and international organizations and development partners, academics, legal experts and health professionals.

3. As part of his visit, the Special Rapporteur visited health facilities in Kuala Lumpur, Melaka and the State of Sabah, including in the Keningau district. He also visited the infirmary of the Kajang Prison (Kuala Lumpur) and two immigration detention centres, the Lenggeng Immigration Depot (Negeri Sembilan) and the Immigration Detention Depot of the Kuala Lumpur International Airport.

4. The Special Rapporteur is grateful to the Government of Malaysia for its invitation and full cooperation during his visit. He would like to take this opportunity to thank the United Nations country team for their support for his visit, and all those who gave him the benefit of their time and experience.

II. Right to health

A. Background

5. The Malaysian economy grew rapidly during the late twentieth century and this growth transformed the country's economic and social landscape. The economy has moved from its initial dependence on natural resources to being dominated by industry and services, and has achieved the status of an upper middle-income country.[1]

6. Malaysia has placed the health of its population at the heart of its development policy since it gained independence in 1957. During his visit, the Special Rapporteur commended the Government for its achievements in improving the health status in the country through a sustained commitment to health policy. Considerable improvements have been made in increasing the life expectancy of large sectors of the population. Overall, life expectancy for women has increased from 65.5 to 77 years between 1970 and 2014, and from 61.6 to 72.4 years for men during the same period.

7. Maternal mortality rates have plummeted from 140.8 deaths per 1,000 live births in 1970 to an estimated 25.6 deaths per 1,000 live births in 2012. Infant mortality rates have more than halved during the same period, from 39.4 deaths per 1,000 live births to an estimated 6.3 per 1,000 live births, reaching ratios similar to those of high-income developed countries. Malaysia is one of three countries in the Association of Southeast Asian Nations (ASEAN) with infant and child mortality rates below 10 per 1,000 live

[1] World Bank data, available from http://data.worldbank.org/country/malaysia.

births. During the same period, the doctor/population ratio has improved from 1 per 4,493 to 1 per 758.[2]

8. The Special Rapporteur commended the achievements related to some of the underlying determinants of health, including the reduction of poverty, improvements in access to water and sanitation and the effective control of outbreaks of recent epidemics. Malaysia has achieved impressive results in reducing poverty, especially in urban areas, where the percentage of households living in poverty has fallen from 21.3 per cent to an estimated 0.5 per cent between 1970 and 2014.[3] However, about 3.4 per cent of rural households still live in poverty.[4] In this respect, the Special Rapporteur noted with concern stark disparities in the enjoyment of basic health indicators between certain groups of the population, with indigenous and migrants particularly affected.

9. The health sector in Malaysia has developed over the past few decades with a strong focus on primary care and has achieved universal coverage for most of its population, as well as fairly good standards of availability, accessibility, acceptability and quality. Malaysia has also made serious attempts to recognize the challenges of the ongoing demographical and epidemiological transition from a country with a focus on communicable diseases to a country where non-communicable diseases are becoming a concern. These include the National Strategic Plan for Non-Communicable Diseases (2010–2014) and the Non-Communicable Disease Prevention in Community programme.

10. However, many of the challenges that the Special Rapporteur identified during his visit are related to a selective approach to human rights. This approach, mostly based on restrictive interpretations of cultural and religious norms and practices, is a departure from universal human rights principles and standards and has reinforced the exclusion and discrimination, in law or practice, of certain groups from the full enjoyment of the right to health.

11. During his visit, the Special Rapporteur also ascertained the challenges and risks that civil society faces when working on right to health issues, particularly when it comes to exercising the rights to freedom of opinion and expression, and freedom of peaceful assembly. Civil society organizations in Malaysia operate in a very restrictive environment and some work in fear of the application of the Sedition Act 1948. Such an environment precludes the existence of one of the crucial preconditions for the effective realization of the right to health: the participation and empowerment of those affected.

B. International and national legal framework

12. While recognizing the above-mentioned achievements in economic development and improving basic health-related indicators, the Special Rapporteur notes that Malaysia has only ratified three of the international human rights treaties: the Convention on the Elimination of All Forms of Discrimination against Women (1995); the Convention of the Rights of the Child (1995) and the first two Optional Protocols thereto (2012); and the Convention on the Rights of Persons with Disabilities (2010). Malaysia has not extended a standing invitation to the special procedures of the Council although it has invited a number of independent experts to visit the country since 2007.

[2] Data from the Economic Planning Unit of the Prime Minister's Department.

[3] Data from the Macroeconomics Section of the Economic Planning Unit.

[4] The World Bank, Global Poverty Working Group, Rural poverty headcount ratio at national poverty lines (percentage of rural population). Available from http://data.worldbank.org/indicator/SI.POV.RUHC.

13. The accession of Malaysia to these conventions is subject to the understanding that they do not conflict with the provisions of sharia law and the Federal Constitution. Therefore, provisions contained in these core international human rights treaties are not directly enforceable in domestic courts. In addition, Malaysia has introduced reservations to key provisions of the treaties that it has ratified, including article 16 of the Convention on the Elimination of All Forms of Discrimination against Women, which are considered to be part of the core obligations of States parties to the conventions.

14. The Special Rapporteur is concerned about the limited number of international human rights treaties that Malaysia has ratified and the reservations that it has introduced to the conventions mentioned, some of them of a general nature, which seriously undermine the nature and scope of the obligations under those treaties. Moreover, he is concerned that the slow pace of reporting to the monitoring bodies has weakened the accountability of the State and could undermine the efforts undertaken so far.

15. Malaysia has not ratified the 1951 Convention relating to the Status of Refugees and its 1967 Protocol. At the regional level, Malaysia ratified the ASEAN Charter in 2008, which establishes that one of the purposes of ASEAN is to promote and protect human rights and fundamental freedoms, with due regard to the rights and responsibilities of its member States.

16. The Federal Constitution of Malaysia contains a number of provisions for the enjoyment of the right to health, directly or indirectly, most of which are contained in articles 5–13. If these rights are infringed, the victim(s) can seize the High Court Division. Legislation in Malaysia related to the realization of the right to health includes the Penal Code and the Criminal Procedure Code. Also worth highlighting are the Dangerous Drugs Act 1952; the Aboriginal Peoples Act 1954; the Immigration Act 1959/63; the Medical Act 1971; the Drug Dependants (Treatment and Rehabilitation) Act 1983; the Care Centres Act 1993; the Private Healthcare Facilities and Services Act 1998; the Human Rights Commission of Malaysia Act 1999; the Child Act 2001; and the Mental Health Act 2001.

III. Health system and financing

17. In Malaysia, the population has enjoyed relatively high standards of health care at affordable levels owing to the post-colonial, welfare-oriented public administrations' strong commitment to public health care. Since the 1980s, basic public health infrastructure, functioning hospitals, primary care and full-fledged rural health services have all been put in place with particular emphasis on universal health coverage as a hallmark to improve the well-being of the population.

18. However, over the past few decades, Malaysia has witnessed the growth of private health-care facilities and a reduction in the role of the State as health-care provider. Private provision and financing of health care has emerged, in certain sectors, encouraged by public policy. One of the results has been that national health expenses have significantly increased and affordability has become a key challenge in ensuring universal access to quality health care. In 2012, public expenditure accounted for 52 per cent of the total health expenditure, private financing for 39 per cent.

19. The Government has set ambitious goals for the health system in its "Vision for Health", in which it stated that "Malaysia is to be a nation of healthy individuals, families and communities through a health system that is equitable, affordable, efficient, technologically appropriate, environmentally adaptable and consumer-friendly".[5] The

[5] Ministry of Health Malaysia, "Strategic Plan (2006–2010)", April 2008, p. 4.

health-care system consists of tax-funded and Government-run universal services and a fast-growing private sector. Public sector health services are organized and are centrally administered by the Ministry of Health, which exerts little regulatory power over the private sector.[6]

20. Malaysia is thus facing the complex challenge of sustaining a relatively good health-care system, so that it can continue to provide accessible and affordable primary health-care, as well as specialized outpatient and inpatient medical services. Elements of that challenge include the increased expectations of health-care consumers; the growth of the private sector and out-of pocket payments in health-care system; the presence of a large population of non-nationals in the working force; and the drain of medical doctors and nurses from public to private sector.

21. The strengths of the health-care system, including the priority given to well-developed and accessible primary care, should continue to be assured and hospitals and specialized outpatient health care developed in a rational and cost-effective way. The Special Rapporteur saw examples of this during his visit, such as the establishment of a widespread network of community clinics, One Malaysia Clinics, and mobile clinics.

22. Public expenditure on health care could and should be strengthened. Overall, the country's expenditure on health has considerably increased over the past few decades, going from 1.3 per cent of the total public expenditure in 2006 to over 8.7 per cent in 2014. However, health-care financing as a share of gross domestic product (GDP) was 4 per cent in 2010 and 4.5 in 2013,[7] which is low according to international standards and should be increased. As an illustration, this share is lower than the 2010 averages in the Americas (8.1 per cent), Europe (7.4 per cent) and the former Soviet republics (5.7 per cent).[8]

23. According to data available,[9] of the 2013 total expenditure on health, out-of-pocket expenditure represented about 39 per cent. In many countries, the primary financial barrier to accessing health care is out-of-pocket payments, which are made by the user for health goods and services at the point of service delivery. While in an upper-middle income country, out-of-pocket expenditure could be seen as reflecting the choice and preferences of certain sectors of the population, data available show that, despite universal coverage, 4 per cent of households in Malaysia incur catastrophic expenditures and the two lowest deciles (poorest groups) spend more out of pocket than the eight other deciles in terms of proportion of income.[10] The phenomenon of out-of-pocket payments can have devastating consequences and push into poverty and socially excluded the most vulnerable groups and those who have most serious health needs.

24. In the opinion of the Special Rapporteur, a health-financing scheme should be introduced so that individuals' ability or inability to pay does not affect their decision whether to access the necessary health goods and services. Financial barriers that restrict access to health care, especially for groups in vulnerable situations, should be removed. There should be more integration and cooperation between public and private sectors. All

[6] Safurah Jaafar and others, "Malaysia Health System Review", *Health Systems in Transition*, vol. 3, No. 1 (2013, Asia Pacific Observatory on Health Systems and Policies).

[7] Data provided by Ministry of Health during the visit.

[8] World Bank, health expenditure, total (% of GDP).

[9] Malaysia National Health Accounts, "Health Expenditure Report 1997–2013".

[10] Malaysia, Ministry of Health, Household Expenditure Survey (2004), cited in "Country Health Plan, 10th Malaysia Plan (2011–2015)", p. 25.

relevant stakeholders should be involved in the process by means of widespread and effective consultations.[11]

IV. Groups in vulnerable situations

25. In addition to the challenges mentioned face the health-care system in Malaysia, the Special Rapporteur identified during his visit important barriers to accessing health care, including with respect to accessibility and affordability affecting some groups of the population.

A. The right to health of women and girls

26. During his visit, the Special Rapporteur learned about key initiatives undertaken, mostly since the 1990s, to improve the situation of women in the country. These include programmes to increase their participation in the workforce and in key decision-making positions, such as the National Plan of Action for the Advancement of Women, and programmes to facilitate access to health care, such as the Mammography Subsidy Programme.

27. Overall, girls and women in Malaysia have access to basic (primary and secondary) health-care services and benefit from improved health indicators, including child and maternal mortality, immunization and life expectancy. Maternal mortality rates have been reduced thanks to increased access to professional care during pregnancy, childbirth and postnatal care, and access to family planning services.

28. Malaysia ratified the Convention on the Elimination of All Forms of Discrimination against Women in 1995 but it has neither incorporated the Convention into national law nor effectively introduced gender equality in its legal framework. This, together with the lack of reporting to the Committee on the Elimination of Discrimination against Women and other treaty bodies, makes it very difficult to properly assess the situation and hold the authorities accountable with respect to compliance with international human rights standards related to non-discrimination against women and gender equality.

29. Although Malaysia has consistently reaffirmed the agenda established by the International Conference on Population and Development in Cairo in 1994 and its Programme of Action (E/CN.9/2014/4), many of the goals on that agenda and set in the follow-up to the Programme of Action have not been adequately addressed. While there has been substantial progress in maternal health indicators, more needs to be done to achieve key goals connected to the enjoyment of the right to health of women and girls, in particular concerning sexual and reproductive health and rights, gender-based violence and harmful traditional practices.

1. Sexual and reproductive health and rights

30. During his visit, the Special Rapporteur noted that women and girls face significant barriers to the full enjoyment of their right to health, in particular when it comes to sexual and reproductive health rights.

31. About one third of the population in Malaysia are adolescents and young people, aged from 10 to 24. The Special Rapporteur acknowledges the formulation of the National

[11] Suhakam "Report on human rights and access to equitable healthcare" (2011), p. xi.

Adolescent Health Policy and the National Adolescent Health Plan of Action (2006–2020) to ensure coordinated delivery of health-care services to this group of the population.

32. However, the Special Rapporteur is concerned that, on the basis of certain restrictive interpretations of religious and cultural values and beliefs which dominate the political discourse and praxis, women and girls do not always have adequate access to comprehensive sexual and reproductive health services or comprehensive sexuality education.

33. The reproductive health services most needed, in particular among girls and young women, include access to safe, reliable and good-quality contraception; comprehensive maternal health services; safe abortion and treatment for complications of unsafe abortion; and prevention and treatment of sexually transmitted infection and HIV/AIDS (see E/CN.9/2014/4, paras. 68–77). These services should be provided irrespective of age and marital status. Evidence shows that access to comprehensive sexuality education has a positive impact on the knowledge and health-related behaviours of adolescents and youth, especially girls and women, as well as on their attitudes about gender equality (see E/CN.9/2014/4, para. 68).

34. Comprehensive sexuality education is not properly integrated into school curricula in Malaysia. Related educational programmes are often not based on evidence and have a stronger emphasis on abstinence than on providing information and education to girls to allow them to make free and informed decisions about their sexuality. This has contributed to the high prevalence of unintended pregnancies amongst girls, high numbers of underage marriages, unsafe abortions and a high risk of the spread of sexually transmitted diseases, including HIV/AIDS.[12]

35. Therapeutic abortion is available in Malaysia (under article 312 of the Criminal Code) and the termination of pregnancy is allowed under specific circumstances, including for saving the life of the mother, and for physical and mental health reasons. In 2012, the Ministry of Health issued Guidelines on the Termination of Pregnancy, in which it is clearly stated that the termination of pregnancy is legal and a service provided in public hospitals. Despite efforts by the authorities, awareness about the legal status of abortion is not yet widespread, neither among women nor among health professionals. An enabling environment is needed to ensure that every woman legally eligible has access to safe abortion care in Malaysia, including by providing the necessary information and training to relevant health professionals and groups of women at risk and by addressing the stigma associated with seeking abortion services or treatment for abortion complications.[13]

2. Gender-based violence

36. Gender-based violence in Malaysia is considered widespread although underreported, and the scope and enforcement of existing legal provisions remains unsatisfactory. Gender-based violence is an issue of concern for public health and is associated with adverse consequences on the physical and mental health of women affected.

37. Domestic violence was reported to the Special Rapporteur as an issue of concern in Malaysia. Although there is little data available about its incidence, anecdotal evidence points to widespread prevalence of intimate partner violence, and non-partner sexual violence. He commended the Government for the adoption of the Domestic Violence Act (1994) and had discussions with the Ministry of Women, Family and Community

[12] World Health Organization (WHO) Western Pacific Region, *Sexual and Reproductive Health of Adolescents and Youths in Malaysia: A review of literature and projects* (2005), p. 51.

[13] See WHO, "Safe abortion: technical and policy guidance for health systems", 2nd ed. (2012).

Development about preventing and monitoring domestic violence in the country. The Special Rapporteur emphasized the need to adopt the inter-agency working together document on handling domestic violence cases, in development since 2010.

38. The Special Rapporteur also commended the establishment of One Stop Crisis Centres to provide integrated services for victims in public hospitals. The centres follow a model of multisectoral response to violence against women, involving Government and non-government actors in the establishment of medical, counselling and police services for victims of violence. He visited some of these centres, which are available in most public hospitals. However, he received testimonies indicating that the centres are at times not sufficiently funded or supported with the appropriate human resources.

39. Sexual harassment is not covered in the law in Malaysia. The Code of Practice on the Prevention and Eradication of Sexual Harassment in the Workplace (1999) is not binding and the existing legal framework does not live up to the standards set therein. While the last amendments to the Employment Act (2012) added a new section to address sexual harassment in the workplace, the new provisions omit psychological harassment, only cover strict employer-employee relationships in the private sector, do not protect inter alia students or domestic workers and do not apply to East Malaysia.

3. Harmful traditional practices

40. The Special Rapporteur expressed concern during his visit about the situation of women and girls who face compounded forms of discrimination owing to their social, cultural and religious backgrounds. This includes the prevalence of child marriage among Muslim and non-Muslim girls, and the practice of female genital mutilation or circumcision among Muslim girls.

41. Child marriage is prevalent among certain groups of the population, including both Muslim and non-Muslim children. Malaysian laws set the legal age of marriage at 18 both for females and males but sharia law lowers this to 16 for Muslim females. There are exceptions to these age limits: non-Muslim girls can marry between 16 and 18 years with a licence from the Chief Minister, while Muslim girls below 16 and boys below 18 can marry with the written permission of the sharia court judge.

42. Child marriage is considered a form of forced marriage and has adverse public health-related consequences, which should be of concern for the authorities. Early marriage is often associated with early and frequent pregnancies which result in higher infant and maternal mortality and morbidity rates. In addition, child marriage causes girls to drop out of school and increases the risk of domestic violence, given the subsequent impact on girls' personal and economic autonomy.[14]

43. While the Special Rapporteur acknowledges that the incidence of early marriage among girls 15–19 years old has decreased between 1970 and 2010,[15] he remains concerned about its prevalence. Moreover, he is very worried about information received indicating that, in an attempt to reduce the incidence of premarital sex, children born out of wedlock and child abandonment, certain authorities are encouraging underage marriage. This goes against international human rights standards, established by the Committee on the Elimination of Discrimination against Women and the Committee on the Rights of the Child, and can represent a regression with respect to the Cairo Programme of Action.

[14] See joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women and general comment No. 18 of the Committee on the Rights of the Child on harmful practices (2014), paras. 19–23.

[15] Department of Economic and Social Affairs, World Marriage Data 2012.

44. Female genital mutilation/cutting, which according to various definitions includes female circumcision under type IV,[16] is practised in Malaysia. The Special Rapporteur expressed concern about the prevalence of this practice and learned that the health authorities have produced guidelines to regulate it. He is concerned that this could be contrary to the global strategy against the medicalization of this harmful practice, as established by the World Health Organization (WHO).[17]

45. The removal, partially or wholly, of the external female genitalia, or otherwise the injury of female genital organs, for non-medical or non-health reasons, can lead to multiple immediate and long-term health consequences. The Special Rapporteur would like to highlight that this is a form of violence against women and girls, even if not intended as an act of violence, and a violation against their basic human rights and fundamental freedoms, including their right to health. Addressing harmful traditional practices is part of the core obligations of States parties to the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child. These practices constitute a denial of the dignity and integrity of those affected; are based on unacceptable discrimination and violence on the basis of sex, gender, age and other grounds; and often cause severe physical and/or psychological harm or suffering.[18]

B. Indigenous communities

46. The indigenous peoples in Malaysia represent around 12 per cent of the total population and include the Orang Asli, or aborigines of Peninsular Malaysia, and the natives of Sabah and Sarawak, also referred to as Orang Asal. The Orang Asli represent about 0.63 per cent of the total population.[19] It is estimated that the natives of Sabah and Sarawak represent about 70 and 60 per cent of the population in the two States, respectively.[20] About 60 per cent of the indigenous population live in rural areas, sometimes in remote locations of difficult access.

47. The indigenous communities in Malaysia all have a struggle to preserve their own ways of life based on customary systems (adat), constantly under pressure owing to profound changes brought by the rapid economic development in the country. Indigenous peoples are among the most marginalized and disadvantaged groups in Malaysia suffering from higher levels of poverty and social exclusion.

48. Malaysia has endorsed the United Nations Declaration on the Rights of Indigenous Peoples but it has not ratified International Labour Organization Indigenous and Tribal Peoples Convention, 1989 (No. 169). The Aboriginal Peoples Act set forth the rights of the Orang Asli to education, health, socioeconomic development and culture and beliefs. In 2010, the Department of Orang Asli Development was established under the Ministry of Rural and Regional Development to provide protection to this group and their way of life in the wake of rapid development. The Orang Asli Development Strategic Plan (2011–2015)

[16] See WHO, "Eliminating Female Genital Mutilation: An Interagency Statement" (2008).

[17] WHO, "Global Strategy to stop health-care providers from performing female genital mutilation" (2010).

[18] See WHO, "Eliminating Female Genital Mutilation" and "Global strategy to stop health-care providers". See also joint general recommendation No. 31 of the Committee on the Elimination of Discrimination against Women and general comment No. 18 of the Committee on the Rights of the Child, paras. 14 and 15.

[19] Data from the Department of Orang Asli Development of the Ministry of Rural and Regional Development.

[20] See Suhakam, National Enquiry into Land Rights of Indigenous Peoples, 2013, para. 2.12.

includes such objectives as expanding access to infrastructure, improving health and cultivating traditional knowledge and heritage.

49. Despite commendable efforts by the part of the Government to address health-related issues affecting the indigenous communities, the Special Rapporteur observed that serious challenges remain with regard to their enjoyment of the right to health and related rights, both in peninsular Malaysia and in Sabah and Sarawak. Health indicators among indigenous populations are significantly worse than those of the general population. Their life expectancy is below 60 years, while the average in Malaysia is over 70 years, and they carry a larger burden of disease, both for communicable and non-communicable diseases, including tuberculosis, malaria and leprosy. Infant and maternal mortality rates are higher than the national averages. Birth registration is a serious problem among indigenous communities living in remote areas with a negative impact on access to health care.

50. Access to health-care services for indigenous populations has significantly improved through the development of the infrastructure for health-care services, mostly primary care in remote areas and specialized care, including a hospital for Orang Asli, the Gombak Orang Asli Hospital. Some initiatives, such as "flying doctors" services or the community-based Village Health Promoter Programme, have improved the accessibility of and participation in health-care services by indigenous communities in remote areas.

51. However, health information is not always accessible in a culturally appropriate manner to the indigenous communities, and they are not always properly informed about or involved in public health decisions that affect them. Language continues to be a barrier to accessing health-care services for indigenous communities in the country.

52. Moreover, the right to health of indigenous people is threatened by changes in the use of land caused by development projects linked to logging operations, palm oil plantations and energy-intensive industries in certain parts of the country, in particular in Sabah and Sarawak. This has led to a substantial loss of access to traditional land and sources of livelihood, resettlement processes and instances of violence, which have had a direct impact on the physical and mental health of these communities.

53. During his visit to Sabah, the Special Rapporteur heard testimonies that, as a consequence of ongoing development projects, some of the communities have lost access to traditional lands and sources of livelihood, which has had a negative impact on their diet and physical health. Testimonies also pointed to a lack of meaningful dialogue between authorities and indigenous communities, and these communities do not have access to basic information about the projects in their region and the potential environmental impact.[21] This can have a serious effect on the mental health and emotional well-being of indigenous communities owing to uncertainties about the security of their livelihood in the future, which leads to chronic stress and anxiety.

54. The Special Rapporteur would like to underline that the right to health should be promoted and protected not only through access to health-care services, which should be available, affordable, appropriate and of good quality. The right to health also implies the design and implementation of cross-sectoral programmes that address socioeconomic, cultural and environmental factors and are guided by a human rights approach, with strong emphasis on the principles of non-discrimination, participation and empowerment and accountability.

[21] See Suhakam, National Enquiry into Land Rights of Indigenous Peoples, para. 6.34.

C. Migrants, refugees and asylum seekers

1. Documented and undocumented migrants

55. Malaysia is a multi-ethnic, multicultural, and multi-religious society that, owing to its geographical location and economic dynamism, has become a main destination of workers' migratory movements in the region, mostly into low-skilled labour, including domestic work. It is estimated that there are currently over 6 million migrant workers in Malaysia, predominantly from Bangladesh, Cambodia, India, Indonesia, Nepal, the Philippines and Sri Lanka, of whom about 2.9 million are undocumented.

56. Malaysia is a party to five of the eight International Labour Organization core conventions that relate to fundamental principles and right at work. But it has neither ratified the Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87) nor the Discrimination (employment and Occupation) Convention, 1958 (No. 111), and it denounced the Abolition of Forced Labour Convention, 1957 (No. 105) in 1990.

57. The Immigration Act, amended in 2002, and modified by the Immigration Regulations 1963, form the cornerstone of the Malaysian immigration system. In addition, the Passports Act 1966 specifies requirements relating to necessary documentation on entering or leaving Malaysia. Before a work permit can be granted, prospective workers must pass a health check. The Foreign Workers Medical Examination Monitoring Agency manages the health screening system of foreign workers in peninsular Malaysia. Fifteen medical conditions automatically disqualify prospective workers, including an HIV-seropositive status and pregnancy. Workers who are renewing work permits must pass the same health tests.

58. The notification of infectious diseases is required by the Prevention and Control of Infectious Diseases Act, and the Immigration Act is used to deport migrant workers with HIV and/or require them to submit to a medical examination if necessary. This policy and practice poses a serious problem with respect to the right not to be discriminated on the basis of health status, the right to privacy and informed consent. In addition, it goes against international guidelines set out by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO regarding HIV testing.[22] Although States may place restrictions on the entry of non-citizens on public health grounds, HIV status is not a reasonable basis for such restrictions.

59. Pregnancy, which is not an illness, also bars migrants from entering Malaysia and, moreover, under current immigration policies a migrant worker who becomes pregnant is subject to immediate dismissal and her work permit is revoked.

60. The Special Rapporteur urges the Government to remove these requirements from the list, both the requirement to be tested for HIV status and for pregnancy. Moreover, both for reasons of public health and to ensure the right to privacy and information, it is essential to ensure that the results of medical examinations are communicated to migrants along with the appropriate health information and counselling.[23]

61. Documented migrants, as non-nationals, face specific barriers when accessing the health-care system, which presumes that migrants place a burden on an overstretched public health system. Migrants and foreign nationals have a limit of five days to access medication

[22] See UNAIDS/WHO Policy Statement on HIV Testing, June 2004.
[23] See ibid., p. 2.

with a prescription for chronic illnesses, which can have devastating effects on the adequate treatment of some illnesses.

62. Moreover, Malaysia has a policy of double fees, which requires migrant workers, like all foreigners, to pay higher fees. This means, in practice, that migrants admitted to public hospitals pay first-class fees, but are entitled only to third-class treatment. The outpatient fee for migrants in public hospitals, which used to be 2 ringitt (as opposed to 1 ringitt paid by Malaysians) was increased to 15 ringitt in 2004. The Special Rapporteur learned about an initiative in 2014 to increase the fees that migrants and non-nationals pay to access public health care. This can have a catastrophic impact on the enjoyment of the right to health of migrants, both documented and undocumented, given their economic vulnerability and low wages.

63. During his visit, the Special Rapporteur also learned about the establishment of immigration counters inside public hospitals to facilitate referrals of undocumented migrants, which often includes asylum seekers, to the police when they come seeking medical attention. He expressed concern that this practice is not only discriminatory but also goes against public health interests and the code of ethics of doctors. While acknowledging that health-care services are de facto available to migrants, including undocumented ones, the Special Rapporteur warned about the potential adverse impact that the establishment of immigration counters, as undocumented migrants will likely be deterred from seeking health care for fear of being reported. This could have a devastating impact on their health status and could cause the spread of communicable diseases, including HIV/AIDS.

64. In that connection, the Special Rapporteur was alarmed by testimonies during his visit about a wave of arrests of undocumented women migrants and asylum seekers who, a few days after giving birth, had been taken from hospitals directly to detention centres. In those centres, some of these women and their babies had reportedly neither received the necessary medical attention nor the appropriate care needed during the postnatal period.

65. The Special Rapporteur called upon the authorities to ensure that law enforcement officers refrain from using medical procedures and medical care facilities for security and immigration purposes. These policies and practices are intrinsically discriminatory on the basis of legal status and country of origin, can create and reinforce health inequalities and can have serious public health consequences (see A/HRC/23/41). It is therefore vital that the Ministry of Health guarantees access and affordability to adequate health care to all groups in Malaysia, including documented and undocumented migrants.

2. Asylum seekers and refugees

66. Asylum seekers and refugees are by definition groups in a vulnerable situation, given the persecution and violence they have faced in their countries of origin and the risks they face if deported back. At end November 2014, there were approximately 150,460 refugees and asylum seekers registered with the Office of the United Nations High Commissioner for Refugees (UNHCR) in Malaysia, the majority of them from Myanmar, but also from countries such as Iraq, Pakistan, Somalia, Sri Lanka and the Syrian Arab Republic. Of these, approximately 30 per cent are women and it is estimated that about 32,710 were children under 18 years of age [24]

67. The vulnerability of this group is exacerbated by the fact that Malaysian law does not provide for the protection of this group, since the country is not a signatory to the 1951 Convention relating to the Status of Refugees or its 1967 Protocol. As a result, asylum

[24] UNHCR Malaysia, Figures at a Glance.

seekers and refugees are subject to the Immigration Act as undocumented migrants, and hence are liable to being imprisoned, whipped or removed.

68. There have been some improvements for refugees and asylum seekers in the country recently, and those who have obtained recognition as "persons of concern" from the UNHCR may be able to enjoy a basic de facto status at the national level. However, these advances have not been codified into laws or written policies that could provide and ensure an appropriate framework of protection.

69. The health needs of refugees and asylum seekers are complex and require special consideration, given their displacement and relocation. In 2005, the Ministry of Health agreed to provide UNHCR-recognized refugees with a 50 per cent discount on fees charged to non-nationals for health-care services in public hospitals, which includes reproductive health, family planning and immunization. Refugees are recognized as one of the target groups under the National Strategic Plan on HIV/AIDS 2011–2015, which gives them access to treatment and medication and could be considered as a good step.

70. However, while health-care services are available for this group, they are not affordable or accessible, especially for asylum seekers. The cost is prohibitive for asylum seekers, who are required to pay full foreign rates and cannot work to support themselves. The sustained fears of arrest, detention and deportation, exacerbated by the measures described above, deter asylum seekers from seeking medical treatment. Language barriers also act a major obstacle to access vital health-related services and information.

71. Despite the fact that Malaysia has not ratified international standards that protect and promote the rights of refugees and asylum seekers, the principle of non-refoulement is part of customary international law. In addition, Malaysia is bound by the obligations contained in the international human rights treaties that it has ratified which cover the rights of these groups.[25]

3. Detention conditions in immigration centres

72. Illegal entry and re-entry in Malaysia is punishable with a fine of up to 10,000 ringgit (about US$ 2,780), imprisonment of not more than five years and whipping of not more than six strokes.[26] Existing migration policy, together with the fact that the country does not recognize the special need for protection of refugees and asylum seekers, leads to high numbers of migrants, refugees and asylum seekers in detention, who are exposed to corporal punishment against the universal prohibition of torture and ill-treatment and the obligations of Malaysia under international law.

73. One of the main concerns relating to migrant workers, refugees, and asylum seekers in detention is their mental and physical health needs. Long periods of detention and poor living conditions facilitate the transmission of communicable diseases and can have devastating effects on the mental health of migrants (see A/HRC/23/41, para. 36). This is exacerbated in the case of asylum seekers and refugees, who often suffer from previous trauma from violence, persecution and displacement.

74. Legislation referring to the administration of immigration detention centres includes the Prisons Act of 1995, the Prisons Regulations of 2000 and the Immigration

[25] Article 22 of the Convention on the Rights of the Child and general comment No. 6 (2005) on treatment of unaccompanied and separated children outside their country of origin, and general recommendation No. 32 (2014) on the gender-related dimensions of refugee status, asylum, nationality and statelessness of women of the Committee on the Elimination of Discrimination against Women.

[26] Immigration Act No. 155, section 6(3).

(Administration and Management of Immigration Depots) Regulation of 2003. Suhakam is the only entity with legal permission to monitor the conditions of detention in these centres, although the International Committee of the Red Cross and UNHCR are allowed to visit on a regular basis. Non-governmental organizations have very limited access to places in which migrants are detained. The Special Rapporteur is encouraged by the fact that the Ministry of Health is now conducting visits on a regular basis to some of the immigration detention centres.

75. The detention conditions in immigration centres have been reported as a source of concern about health (see A/HRC/16/47/Add.2).[27] During his visit, the Special Rapporteur had access to the Lenggeng Immigration Depot (Negeri Sembilan) and the Immigration Detention Depot of the Kuala Lumpur International Airport (Sepang, Selangor).

76. During his visit to the Lenggeng Depot, the Special Rapporteur found out that women who have just given birth are held in a separate area where they have mattresses for them and their babies and are provided with the necessary hygienic products. However, their diet does not seem sufficient for breastfeeding mothers as it was reported that they only get two meals per day. In addition, access to clean water seems to be only upon request and some of these women are reportedly not allowed to spend enough time outside the common cell, including with their babies.

77. In the Lenggeng Depot, the Special Rapporteur heard of two cases of migrants held in isolation cells due to mental health issues. He learnt that, in such cases, sufferers do not receive specialized medical attention and one migrants had been in detention for over a year. Both women seemed in good physical condition, but isolation cells are too small and should not be used for the same person for prolonged periods of time.

78. The Special Rapporteur regrets that during his visit to Lenggeng he could not finish an interview with a group of women because he was interrupted by an immigration officer arguing security concerns. International standards that apply to monitoring places of detention specify that interviews should be conducted out of sight and earshot of the authorities responsible for the management of the facilities.

79. During his visit to the Immigration Detention Depot of the Kuala Lumpur International Airport, the Special Rapporteur found out that the conditions in the male wards were not up to international standards. Men held there have to sleep on concrete floors, do not always get blankets when the weather is cold and do not have access to soap to wash their clothes. He also found one minor who had been held with adults for more than nine months, and a mental health patient unidentified and not properly treated.

80. In that depot, the Special Rapporteur visited the female ward and met with number of children of Rohingya origin, aged from 4 to 12 years old, who had been held for a period of five to seven months, some of them with special health needs. The detention of children with their parents has a detrimental effect of their physical and mental health and should be avoided; non-custodial alternatives should be explored. A decision to detain migrants who are accompanied by their children should only be taken in very exceptional circumstances and States should always try to preserve the family unit by using alternatives to detaining the entire family (see A/HRC/20/24, para. 40).

81. The right to health requires States to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable groups, as well as to the underlying determinants of health.[28] Prisoners and detainees are in a particularly

[27] See also Suhakam, Roundtable on Alternatives to Immigration Detention, November 2013, p. 6.

[28] General comment No. 14 of the Committee on Economic, Social and Cultural Rights, paras. 35, 36 and 43(a).

vulnerable situation due to their complete reliance on the State for food, shelter, and access to health goods and services.

82. In addition, the Standard Minimum Rules for the Treatment of Prisoners provide for standards related to the availability and accessibility of health care in prisons as well as the underlying determinants of health. The Basic Principles for the Treatment of Prisoners and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment provide for free and non-discriminatory access of prisoners to the same health services available outside the penitentiary system in the place of detention or imprisonment.

D. Lesbian, gay, bisexual and transgender persons

83. Although discrimination on the basis of gender is prohibited in the Federal Constitution (art. 8 (2)), the rights of lesbian, gay, bisexual, and transgender (LGBT) persons are not explicitly recognized. Colonial-era provisions have been retained under the Penal Code and they criminalize sodomy (Penal Code, sects. 377(a) and 377(b)) and perpetuate discrimination against LGBT persons. In addition, discriminatory societal attitudes towards LGBT persons prevail in Malaysia and have been exacerbated over the past few decades by the use of a stigmatizing rhetoric by politicians, public officials and religious leaders.

84. Malaysia has become one of the few countries where transgender people are criminalized. Since the 1980s, a series of legislative initiatives, mostly undertaken under sharia enactments, prohibited "cross dressing" and forced transgender people, who had historically enjoyed a certain degree of acceptance in society, to go underground. In 1982, a fatwa issued by the National Fatwa Council, prohibited Muslims from undergoing sex reassignment surgery and since then very few hospitals have performed such surgery. The National Registration Department does not allow the gender indicator on identity cards to be changed, and this applies both to Muslims and non-Muslims.

85. Some Government institutions have recognized the health needs of transgender persons. The Ministry of Health has included transgender persons and men who have sex with men as a group at risk under the National Strategic Plan on HIV/AIDS 2011–2015, which gives them access to treatment and medication and is a positive step.

86. The criminalization of same-sex conduct and of different forms of gender identity and expression has reinforced negative societal attitudes and has led to serious human rights violations of the rights of this group of the population, including significant barriers in access to health care. Law enforcement officials arrest transgender women and subject them to various abuses, including humiliation in the media, and physical and verbal abuse.

87. Transgender women also face serious discrimination in public health-care facilities. They are often associated with sex work, which is a crime, and they are forcibly tested for HIV/AIDS. They are identified on the basis of their identity card and, unless they have undergone sex reassignment surgery, are often housed in male wards where they can be exposed to violence and abuse. The fear of stigma and discrimination deters transgender women, and other LGBT people, from seeking health care, with the consequent devastating effects that this can have.

88. The Special Rapporteur welcomes the judgement of the Court of Appeal issued on 7 November 2014 that found section 66 of the Syariah Criminal Enactment of Negeri

Sembilan State criminalizing cross-dressing unconstitutional.[79] The judgement of the Court of Appeal stated that section 66 of the Syariah enactment was not in conformity with the Federal Constitution and violated the rights to live with dignity, equality before the law and non-discrimination, and directly affected freedom of movement and expression. The judgement explicitly acknowledges the profound effect that section 66 has on the appellants who live perpetually at risk of arrest and prosecution simply because they express their gender identity. The Court of Appeal underlined that the existence of a law that punishes gender expression is degrading and deprives those affected of their dignity and value in society.

89. Laws that criminalize same-sex conduct, as well as legal enactments that criminalize transgender women, infringe on the enjoyment of the right to health and other basic human rights (see A/HRC/14/20, para. 6) which are guaranteed by the Federal Constitution and the international treaties that Malaysia has ratified, including the human rights to dignity, equality before the law and equal protection of the law, freedom from discrimination and freedom of expression.

90. During his visit, the Special Rapporteur was also very concerned about information received on programmes and practices supported by public institutions to change the sexual orientation of adolescents, so-called "corrective therapies". Such therapies are not only unacceptable from the human rights perspective but they are also against scientific evidence, and have a serious negative impact on the mental health and well-being of adolescents. State-led programmes to identify, "expose", and punish LGBT adolescents contribute to a detrimental educational environment where the inherent dignity of the child is not respected and discrimination on basis of sexual orientation and gender identity is encouraged.

E. Persons living with HIV/AIDS and drug users

91. The Government is to be commended on measures taken to reduce the spread of HIV/AIDS. As a result, there has been a significant reduction of more than half in new cases, from 28.4 per 100,000 persons in 2002 to 11.42 cases per 100,000 persons in 2012. The number of persons living with HIV in 2013 was estimated at 86,324.

92. Malaysia is a country with a concentrated HIV epidemic, with infection rates that remain high, above 5 per cent, among most-at-risk populations, which include drug users, sex workers, transgender persons and men having sex with men.[80] Measures have included making available evidence-based treatment, such as antiretroviral treatment and the implementation of harm reduction programmes, most of which have been in place since 2005.

93. Over the past decades, the Government's response has evolved to include the input of a group of stakeholders, including from non-health units within government agencies, civil society actors, private agencies and bilateral and international agencies. In 1992, the Malaysian AIDS Council was established under the auspices of the Ministry of Health to complement the country's responses, with special focus on the most-at-risk populations. This multisectoral and multi-stakeholder response to the pandemic has contributed to achieving positive results.

[79] Malaysia, Court of Appeal, Civil Appeal No. N-01-498-11/2012.

[80] See Malaysia, Ministry of Health, "Global AIDS Response Progress Report Malaysia" (2014).

94. Nevertheless, in recent years, Malaysia has seen a surge in HIV/AIDS infections due to sexual transmission, mainly affecting men having sex with men, but now also women.[31] The previous success in addressing the epidemic has been somewhat hampered by a lack of full adherence to universal human rights obligations and principles, and the subsequent lack of recognition of the rights of the groups most affected, including LGBT persons.

95. The experience of the HIV/AIDS pandemic has shown that the exposure of vulnerable groups to HIV/AIDS is reinforced through discrimination, stigmatization and disrespect for human rights. Discriminating and ostracizing vulnerable groups will only add to the continuation and further spread of HIV/AIDS. In order to address the increasing rate of sexual transmission of HIV, the Special Rapporteur encourages the authorities to step up their efforts and offer comprehensive sexuality education, which is a key component of the fight against AIDS.

96. Regarding drug policy and the situation of drug users, Malaysia has ratified the three International Drug Control Conventions. The Dangerous Drugs Act describes the punishments for drug-related crimes. Under this act, the possession of 5–15 grams of heroin can result in a life sentence, while possession of more than 15 grams may result in the death penalty. Drug trafficking is also liable to capital punishment.[32]

97. In Malaysia, drug users are forcibly confined to rehabilitation camps, known as Cure and Care Rehabilitation Centres, and receive treatment without their explicit and informed consent. The Drug Dependants (Treatment and Rehabilitation) Act established compulsory drug treatment centres, placed under the supervision of the Ministry of Home Affairs. Upon arrest, drug users undergo drug-use testing. If the test is positive, the person using drugs appears before a magistrate, who can send the user to a drug treatment centre for a period of two years. In these centres, HIV testing is compulsory upon arrival and treatment is mostly abstinence-based, although limited methadone maintenance and anti-retroviral treatments have been introduced. Treatment is still closely supervised by staff, which includes military personnel and security officers, with limited knowledge and skills in health.[33] According to data available, the relapse rate of drug users held in compulsory detention centres was up to 90 per cent.[34]

98. The Special Rapporteur would like to underline that the right to health includes the right to be free from non-consensual medical treatment and requires the informed consent of all who possess legal capacity be obtained prior to the administration of medical treatment (A/64/272). Punitive drug policy regulatory frameworks tend to result in more health-related harms than those they seek to prevent (see A/65/255). A human rights focus on drug policy and control should place the emphasis on voluntary, medically assisted and evidence-based approaches.

F. Children and the right to health

99. The right to health of children has progressed significantly over the past few decades. Malaysia has achieved good results in the area of right to life and survival, reaching and sustaining low rates of infant and children under-5 mortality, and high coverage of child immunization programmes. Recently, there have been effective efforts to

[31] International AIDS Society, "HIV and AIDS in Malaysia: Fact sheet", seventh IAS Conference on HIV pathogenesis, treatment and prevention, 30 June–3 July 2013, Kuala Lumpur.

[32] Dangerous Drugs Act, sects. 39(a) and (b).

[33] WHO, "Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Vietnam" (2009), pp. 19–26 and 28.

[34] Malaysia Mental Health Association, "Substance abuse — emerging trends (2013)".

prevent non-communicable diseases from childhood, for example by promoting healthy lifestyles and preventing under-nutrition, as well as excess weight and obesity.

100. Malaysia acceded to the Convention on the Rights of the Child in 1995 but still maintains reservations to core articles of the Convention, including articles 2, 7, 14, 28 (1) (a) and 37. As stated above, there remain inconsistencies in the definition of the child in national legislation, both civil and sharia law. The Child Act was enacted in 2001 and the National Child Policy and the National Child Protection Policy, with its Action Plan, were introduced in 2009.

101. Many recommendations made by the Committee on the Rights of the Child in 2007 have not been properly addressed, and important challenges remain, mainly concerning the girl child and children from disadvantaged groups, including indigenous children, children with disabilities, refugee and asylum-seeking children, undocumented migrant children and LGBT children.

102. The Special Rapporteur underlined the lack of recognition of the right of children to holistic development as the main cross-cutting issue. This, in his view, has led to the lack of sustainable policies and measures to promote the emotional and social well-being of children, to protect them from all forms of violence, including sexual violence, and to enhance the ability of parents and teachers to raise and educate children using non-violent methods.

103. The Special Rapporteur identified prevailing attitudes supporting punitive measures for children and the use of violence as a remedy, both in public and private settings. This is reinforced by national and local authorities, for example through the use of corporal punishment in schools, often against LGBT adolescents, which goes against the universal prohibition of torture and ill-treatment. He sees this as a serious systemic issue with a detrimental impact on society's physical and mental health and well-being, ranging from child-rearing practices to public decision-making when addressing social problems.

104. The Special Rapporteur raised the issue of bullying in schools and its detrimental impact on the right to health of children, including mental health. He was encouraged by the reaction of the authorities, acknowledging the problem and underlining their commitment to address its root causes. However, he regrets the absence of modern whole-school approaches that advocate, by educating school communities, zero tolerance of any form of violence. Instead, he had access to information indicating that the approach is, once again, of a punitive nature, offering schools the option of inviting the police to station auxiliary personnel to tackle the issue.[15] The Special Rapporteur urges the authorities to reconsider this initiative, as it will undermine the role of schools as educational institutions and will contribute to perpetuating punitive approaches that do not foster the emotional and social well-being of children in society.

G. Persons with developmental and psychosocial disabilities

105. During the visit, the Special Rapporteur learned about important positive initiatives implemented regarding community-based services for persons with psychosocial disabilities and the integration of psychiatric inpatient units in general public hospitals. He visited a mental health community centre in Putrajaya and was impressed by the approach and the level of the health professionals with whom he met.

[15] Johor Baru, "Police will help schools handle bullies at schools", *The Sun Daily*, 26 November 2014.

106. However, there is still a long way to go in order to achieve the full realization of rights of children and adults with developmental and psychosocial disabilities in the country. Although Malaysia ratified the Convention on the Rights of Persons with Disabilities in 2010, and the Mental Health Act was adopted in 2008, the Special Rapporteur was concerned that certain public policies and services are not in accordance with the Convention's standards. This is connected to the reservations made to the Convention, which limit the application of the core principles of non-discrimination and equality.

107. The infrastructure of user-friendly, community-based services for these groups is not yet well developed, which can lead to systemic violations of their rights, such as right to enjoy living in community and other rights. There are certain initiatives of inclusive education of children with disabilities in mainstream schools but they need further support and development. The Special Rapporteur was concerned about the high prevalence of stigmatization and discrimination of persons living with psychosocial disabilities, which makes it difficult to provide the full spectrum of effective and inclusive community-based services, including health-care services.

V. Conclusion and recommendations

108. **The Special Rapporteur notes with appreciation the progress made in Malaysia since independence, in particular, the significant reduction of poverty and the Government's commitment to improving the health of the population. The Government has recognized that the further successful development of the country depends not just on investing in economic growth but also on the social well-being of the population. It has taken steps to improve the well-being of the population, some of which could serve as an inspiration to other countries.**

109. **However, during his visit, the Special Rapporteur observed deeply entrenched discriminatory attitudes towards groups in vulnerable situations, mostly based on certain restrictive interpretations of culture or religion that discriminate and restrict the rights of these groups, including the right to health. These arguments go against international human rights principles and standards, and when initiated, supported or tolerated by public authorities, they threaten the development of a healthy and inclusive society.**

110. **Malaysia needs to move away from a selective approach to human rights. The rights of all people living in Malaysia need to be protected, and more efforts are needed to combat the discrimination of the more disadvantaged groups and to achieve their full inclusion in society.**

111. **The Special Rapporteur recommends that the Government:**

(a) Ratify all core universal human rights treaties and the optional protocols thereto, remove all reservations to the treaties ratified and ensure timely reporting to the monitoring bodies; and extend an standing invitation to the special procedures of the Human Rights Council;

(b) Ratify the 1951 Convention relating to the Status of Refugees and its 1967 Protocol in order to ensure adequate protection of refugees and asylum seekers;

(c) Preserve the strengths of the health-care system and ensure adequate, equitable and sustainable financing for health, increase national budget allocations for health and reduce out-of-pocket expenditure;

(d) Ensure that the health system is funded progressively through universal contributions, based on individuals' and families' ability to pay, and that it provides exemptions for the poor;

(e) Ensure that barriers to access sexual and reproductive rights of girls and women in Malaysia are removed, including by providing, regardless of age and marital status, sexual and reproductive health services and comprehensive adequate sexuality education and information;

(f) Adopt the inter-agency "working together" document to handle domestic violence cases", establish the Committee that would implement such guidelines and make sure that civil society actors are well involved;

(g) Adopt a law to prevent and eradicate sexual harassment that effectively protects all men and women from this type of violence;

(h) Ensure that the legal age for marriage is set at 18 years of age, as established in international human rights standards, and do its utmost to eradicate and prevent child marriage and the negative effects it has on the health and well-being of girls;

(i) Harmonize national legislation and customary and religious laws with international human rights standards, and the introduce a legal prohibition of harmful practices, including female genital mutilation or female circumcision, supported by initiatives to prevent and address those practices;

(j) Take the necessary measures so that indigenous communities enjoy their right to health by ensuring access to information and that health services are available, accessible, affordable, adequate and of good quality;

(k) Involve indigenous communities in the health decisions that affect them by consulting them in advance on relevant policies and providing health-related information in a culturally sensitive manner;

(l) Eliminate discriminatory provisions from the foreign workers' health-screening policy and legal framework, including by removing the mandatory test of migrants for HIV/AIDS and the provision excluding pregnant women;

(m) Ensure that non-nationals, in particular undocumented migrants, refugees and asylum seekers, can afford to access public health care, and consider exempting them from the increase in fees;

(n) End the practice of establishing immigration counters in public hospitals, and of arresting undocumented migrant and asylum-seeking women who have just given birth in these hospitals;

(o) Ensure that the conditions of immigration detention centres are up to international standards, and ensure that they are regularly monitored by the relevant authorities and institutions, including the Ministry of Health, Suhakam, the International Committee of the Red Cross, and UNHCR;

(p) Make sure that children are not detained in immigration detention centres, and find suitable alternatives to their detention that preserve the family unit and providing such children with the necessary environment and services;

(q) Decriminalize sodomy and remove any legal provisions that criminalize same-sex conduct and different forms of gender identity and expression so as to guarantee that the existing legal framework is in accordance with the Federal Constitution and international human rights law.

(r) Legally recognize the gender identity of transgender people and prohibit any discrimination on the basis of gender identity in all areas, including health, education, employment and access to public services;

(s) Put an end to State-led programmes that expose and punish LGBT children, and ensure that they enjoy safe and enabling spaces in schools, and other public and private institutions;

(t) Address new trends of the HIV/AIDS epidemic with non-discriminatory policies and comprehensive educational and information campaigns;

(u) Amend the Drug Dependants Act to remove compulsory drug treatment and HIV testing, and make sure that voluntary, medically assisted and evidence-based approaches are used;

(v) Ban corporal punishment in public and private settings, and change the focus of child policies to move away from punitive approaches to promote the well-being and autonomy of children;

(w) Continue developing a system of user-friendly community-based services for children and adults with developmental and psychosocial disabilities, and ensure that the rights of these persons are respected, promoted and protected in accordance with the standards set by the Convention on the Rights of Persons with Disabilities.